

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05726

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Swanton,		c. LENGTH OF STAY IN lb 79 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 15 Mi. N.E. Swanton, Md.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Swanton	
3. NAME OF DECEASED (Type or print) First Ezra Middle Broadwater Last Broadwater		4. DATE OF DEATH May 17, 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 13, 1878
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months 79 Days 17	IF UNDER 24 HRS. Hours 19 Min. 58
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm	
11. BIRTHPLACE (State or foreign country) Maryland.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Broadwater		14. MOTHER'S MAIDEN NAME Betty Miller	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Merle Wilt		Address Deer Park, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH INSTANT			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____ Month, Day, Year _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>James H. Feaster, Jr.</i>		DATE SIGNED 5-18-58	
EXAMINER'S NAME (Type) James H. Feaster, Jr., M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5/20/1958	22c. NAME OF CEMETERY OR CREMATORY Broadwater Cemetery	22d. LOCATION (City, town, or county) Garrett County (State) Md. near Savage River, Md.
23. FUNERAL DIRECTOR'S SIGNATURE <i>A. C. Reighton</i>		ADDRESS Oakland, Md.	
24a. REC'D BY REGISTRAR MAY 23 '58		24b. REGISTRAR'S SIGNATURE <i>Overland</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 5 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED _____		SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	
AGE _____		DATE OF BIRTH _____	
PLACE OF BIRTH _____		OCCUPATION _____	
MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		PLACE OF DEATH _____	
CAUSE OF DEATH _____		MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide	
TIME OF DEATH _____		PLACE OF INTERMENT _____	
SIGNATURE OF EXAMINER _____		SIGNATURE OF WITNESS _____	
DATE _____		CITY _____	
COUNTY _____		STATE _____	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5737

CERTIFICATE OF DEATH

Reg. Dist. No.

05727

1. PLACE OF DEATH a. COUNTY <u>Garrett</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Garrett</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Accident</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Arthur</u> Middle <u>Ray</u> Last <u>Butler</u>		4. DATE OF DEATH Month <u>May</u> Day <u>23</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 10, 1902</u>
9. AGE (In years last birthday) <u>56</u> yrs.		IF UNDER 1 YEAR Months <u>5</u> Days <u>13</u> Hours <u>15</u> Min. <u>00</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Custodian</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Northern High</u>	
11. BIRTHPLACE (State or foreign country) <u>Grantsville, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Kanada Butler</u>		14. MOTHER'S MAIDEN NAME <u>Sara McClosky</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>214-10-4719</u>	
17. INFORMANT <u>Mrs Edith Butler, Accident, Md. Rd.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>10 yrs.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>15 min</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb 15, 1958</u> , to <u>May 23, 1958</u> , that I last saw the deceased alive on <u>May 21, 1958</u> , and that death occurred at <u>12:30 M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A. Paige Strong</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>5/25/58</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5/26/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Grantsville</u>	22d. LOCATION (City, town, or county) (State) <u>Grantsville, Garrett Co., Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Don Newman</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 27 1958</u>	
ADDRESS <u>Grantsville, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>W. L. Lewis</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5738 CERTIFICATE OF DEATH

Reg. Dist. No. 05728

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland,			c. LENGTH OF STAY IN 1b 3 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oldtown 01X-2				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cuppitt Nursing Home				d. STREET ADDRESS Main St.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Richard Middle Deffinbaugh Last Deffinbaugh				4. DATE OF DEATH Month May Day 2, Year 19 58					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 18, 1876			
9. AGE (In years lost birthday) 81 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber			10b. KIND OF BUSINESS OR INDUSTRY Barbering		11. BIRTHPLACE (State or foreign country) Warrior Mt. Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Richard Deffinbaugh				14. MOTHER'S MAIDEN NAME Margaret M. Hamilton					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No,		16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Floyd Carder Oldtown, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 443X IMMEDIATE CAUSE (a) Heart Disease DUE TO Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 30, 19 56 to May 2, 19 58 , that I last saw the deceased alive on May 2, 19 58 , and that death occurred at 10:00 A.M. from the causes and on the date stated above.									
ACTUAL SIGNATURE J. W. Wenzel				ADDRESS (Street, city or town, state) Oakland Md.				DATE SIGNED 5/2/58	
PHYSICIAN'S NAME (Type) J. W. Wenzel, M. D.				Oakland, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/5/58		22c. NAME OF CEMETERY OR CREMATORY Oldtown Cemetery		22d. LOCATION (City, town, or county) (State) Oldtown, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR DATE MAY 6 58		24b. REGISTRAR'S SIGNATURE Alfred	

MASSACHUSETTS DEPARTMENT OF HEALTH - BATHING

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5739 CERTIFICATE OF DEATH

Reg. Dist. No.

05729

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WEST VIRGINIA b. COUNTY PRESTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND		c. LENGTH OF STAY IN 1b 3 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LULA Middle FLORENCE Last DUMIRE		4. DATE OF DEATH Month MAY Day 11 Year 1958	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 26, 1901
9. AGE (In years last birthday) 57 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	
11. BIRTHPLACE (State or foreign country) AURORA, W.VA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME AMOS SNYDER		14. MOTHER'S MAIDEN NAME CANILLA HENLINE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT WILLIS H. DUMIRE (HUSBAND)		Address HORSE SHOE RUN, W.VA.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Port Operative Thyroid Crisis 252.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Nodular Thyroid Adenomata DUE TO (c) 47 yrs.		INTERVAL BETWEEN ONSET AND DEATH 20 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 20, 1957 to MAY 11, 1958 , that I last saw the deceased alive on MAY 11, 1958 , and that death occurred at 3:10 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Herbert H. Leighton M.D.		ADDRESS (Street, city or town, state) 77 Oak St. Oakland, Md. DATE SIGNED May 13/58	
PHYSICIAN'S NAME (Type) HERBERT H. LEIGHTON, M.D.		OAKLAND, MARYLAND 5/11/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 14, 1958	
22c. NAME OF CEMETERY OR CREMATORY Accident		22d. LOCATION (City, town, or county) (State) Horse Shoe Run W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Wayne C. Spiggle		24a. REC'D BY REGISTRAR Davis, Wm DATE MAY 16 '58	
24b. REGISTRAR'S SIGNATURE W. Davis			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

7

1. Name of deceased		2. Sex		3. Age	
4. Date of death		5. Time of death		6. Place of death	
7. Cause of death		8. Manner of death		9. Signature of physician	
10. Signature of registrar		11. Signature of informant		12. Date of registration	
13. Name of informant		14. Address of informant		15. Telephone number	
16. Name of funeral home		17. Address of funeral home		18. Telephone number	
19. Name of cemetery		20. Address of cemetery		21. Telephone number	
22. Name of undertaker		23. Address of undertaker		24. Telephone number	
25. Name of physician		26. Address of physician		27. Telephone number	
28. Name of registrar		29. Address of registrar		30. Telephone number	
31. Name of informant		32. Address of informant		33. Telephone number	
34. Name of funeral home		35. Address of funeral home		36. Telephone number	
37. Name of cemetery		38. Address of cemetery		39. Telephone number	
40. Name of undertaker		41. Address of undertaker		42. Telephone number	
43. Name of physician		44. Address of physician		45. Telephone number	
46. Name of registrar		47. Address of registrar		48. Telephone number	
49. Name of informant		50. Address of informant		51. Telephone number	
52. Name of funeral home		53. Address of funeral home		54. Telephone number	
55. Name of cemetery		56. Address of cemetery		57. Telephone number	
58. Name of undertaker		59. Address of undertaker		60. Telephone number	
61. Name of physician		62. Address of physician		63. Telephone number	
64. Name of registrar		65. Address of registrar		66. Telephone number	
67. Name of informant		68. Address of informant		69. Telephone number	
70. Name of funeral home		71. Address of funeral home		72. Telephone number	
73. Name of cemetery		74. Address of cemetery		75. Telephone number	
76. Name of undertaker		77. Address of undertaker		78. Telephone number	
79. Name of physician		80. Address of physician		81. Telephone number	
82. Name of registrar		83. Address of registrar		84. Telephone number	
85. Name of informant		86. Address of informant		87. Telephone number	
88. Name of funeral home		89. Address of funeral home		90. Telephone number	
91. Name of cemetery		92. Address of cemetery		93. Telephone number	
94. Name of undertaker		95. Address of undertaker		96. Telephone number	
97. Name of physician		98. Address of physician		99. Telephone number	
100. Name of registrar		101. Address of registrar		102. Telephone number	

1. Name of deceased
2. Sex
3. Age
4. Date of death
5. Time of death
6. Place of death
7. Cause of death
8. Manner of death
9. Signature of physician
10. Signature of registrar
11. Signature of informant
12. Date of registration
13. Name of informant
14. Address of informant
15. Telephone number
16. Name of funeral home
17. Address of funeral home
18. Telephone number
19. Name of cemetery
20. Address of cemetery
21. Telephone number
22. Name of undertaker
23. Address of undertaker
24. Telephone number
25. Name of physician
26. Address of physician
27. Telephone number
28. Name of registrar
29. Address of registrar
30. Telephone number
31. Name of informant
32. Address of informant
33. Telephone number
34. Name of funeral home
35. Address of funeral home
36. Telephone number
37. Name of cemetery
38. Address of cemetery
39. Telephone number
40. Name of undertaker
41. Address of undertaker
42. Telephone number
43. Name of physician
44. Address of physician
45. Telephone number
46. Name of registrar
47. Address of registrar
48. Telephone number
49. Name of informant
50. Address of informant
51. Telephone number
52. Name of funeral home
53. Address of funeral home
54. Telephone number
55. Name of cemetery
56. Address of cemetery
57. Telephone number
58. Name of undertaker
59. Address of undertaker
60. Telephone number
61. Name of physician
62. Address of physician
63. Telephone number
64. Name of registrar
65. Address of registrar
66. Telephone number
67. Name of informant
68. Address of informant
69. Telephone number
70. Name of funeral home
71. Address of funeral home
72. Telephone number
73. Name of cemetery
74. Address of cemetery
75. Telephone number
76. Name of undertaker
77. Address of undertaker
78. Telephone number
79. Name of physician
80. Address of physician
81. Telephone number
82. Name of registrar
83. Address of registrar
84. Telephone number
85. Name of informant
86. Address of informant
87. Telephone number
88. Name of funeral home
89. Address of funeral home
90. Telephone number
91. Name of cemetery
92. Address of cemetery
93. Telephone number
94. Name of undertaker
95. Address of undertaker
96. Telephone number
97. Name of physician
98. Address of physician
99. Telephone number
100. Name of registrar
101. Address of registrar
102. Telephone number

5740

CERTIFICATE OF DEATH

05730

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY GARRETT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY GARRETT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL HOSPITAL		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First JAMES Middle MAHLON Last GLOTFELTY, JR.		4. DATE OF DEATH Month MAY Day 6 Year 1958	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 4, 1958
9. AGE (In years last birthday) -- yrs.		IF UNDER 1 YEAR Months 2 Days 2 Hours 2 Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NEWBORN		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JAMES MAHLON GLOTFELTY, SR.		14. MOTHER'S MAIDEN NAME JESSIE RUTH BITTNER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Address "FATHER", 63 CENTER STREET, OAKLAND, MARYLAND			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity 7605 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Intermenstrual hemorrhage DUE TO (c) Intermenstrual hemorrhage			INTERVAL BETWEEN ONSET AND DEATH 48 hrs 48 hrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from MAY 4, 1958 , to MAY 6, 1958 , that I last saw the deceased alive on MAY 6, 1958 , and that death occurred at 12:12a M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 582nd OAKLAND - 1 5-6-58			
ACTUAL SIGNATURE James H. Feaster, Jr.		M.D. 582nd OAKLAND - 1 5-6-58	
PHYSICIAN'S NAME (Type) JAMES H. FEASTER, JR., M.D. OAKLAND, MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 5/7/1958	22c. NAME OF CEMETERY OR CREMATORY Ferndale Cemetery	22d. LOCATION (City, town, or county) (State) near Oakland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE H. C. Leighton		ADDRESS Oakland, Md.	24a. REC'D BY REGISTRAR DATE MAY 9 '58
		24b. REGISTRAR'S SIGNATURE W. L. Leighton	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2070208XV3

CERTIFICATE OF DEATH

FILE NO.

DATE OF DEATH

DECEASED

NAME

AGE

SEX

RACE

RELIGION

EDUCATION

OCCUPATION

RESIDENCE

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF DEATH

MANNER OF DEATH

DATE OF INTERMENT

PLACE OF INTERMENT

NAME OF MINISTER

NAME OF CLERGYMAN

NAME OF FUNERAL HOME

NAME OF CEMETERY

NAME OF BURIAL

NAME OF CREMATION

NAME OF URN

NAME OF CASK

NAME OF COFFIN

NAME OF CASKET

NAME OF CASKET

NAME OF CASKET

NAME OF CASKET

NAME OF CASKET

NAME OF CASKET

NAME OF CASKET

FILE NO.

DATE OF DEATH

NAME OF DECEASED

NAME OF DECEASED

5741 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY GARRETT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND		c. LENGTH OF STAY IN IB 6 1/2 HOURS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First IDA Middle JANE Last GRUBB		4. DATE OF DEATH Month MAY Day 11 , Year 19 58	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 26, 1874
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	
11. BIRTHPLACE (State or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? UNITED STATES	
13. FATHER'S NAME Jesse Shreve GRUBB		14. MOTHER'S MAIDEN NAME ELIZA ARMENTROUT	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. ----	
17. INFORMANT RUTH GRUBB (DAUGHTER), OAKLAND, MARYLAND		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardiovascular Disease DUE TO (c) 20 yrs.		INTERVAL BETWEEN ONSET AND DEATH 7 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from February , 19 57 , to MAY 11 , 19 58 , that I last saw the deceased alive on MAY 11 , 19 58 , and that death occurred at 3:20 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Herbert H. Leighton M.D.		ADDRESS (Street, city or town, state) 77 Oak St. Oakland, Md.	
PHYSICIAN'S NAME (Type) HERBERT H. LEIGHTON, M.D.		DATE SIGNED 5/11/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/13/1958	
22c. NAME OF CEMETERY OR CREMATORY Pope Cemetery		22d. LOCATION (City, town, or county) (State) near Gorman, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE H. C. Leighton		ADDRESS Oakland, Md.	
24a. REC'D BY REGISTRAR 14 58		24b. REGISTRAR'S SIGNATURE W. J. ...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be signed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

05732

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY GARRETT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE W.VA. b. COUNTY PRESTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAKLAND,		c. LENGTH OF STAY IN 1b 2 HOURS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL HOSPITAL		d. STREET ADDRESS KINGWOOD 85x-3	
3. NAME OF DECEASED (Type or print) First DONALD (BABY) LEE (BOY) Middle HEBB Last HEBB		4. DATE OF DEATH Month MAY 26 Day 19 Year 58	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 26, 1958
9. AGE (In years last birthday) yrs. 3		10. IF UNDER 1 YEAR Months 3	10. IF UNDER 24 HRS. Days 3 Hours 3 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME JAMES JOHNSON HEBB		14. MOTHER'S MAIDEN NAME DOROTHY ALICE SIMMONS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT JAMES J. HEBB		Address Box # 274 - KINGWOOD, W.VA.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxiation 773.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 3 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 566 8		20f. (City or town) (County) (State) 57	
21. I certify that I attended the deceased from 11:24 AM 19 58 to 1:55 PM 19 58 , that I last saw the deceased alive on 3/26/58 19 58 , and that death occurred at 11:52 M., from the causes and on the date stated above		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE Charles E. Smith M.D.		TERRA ALTA WEST VIRGINIA	
PHYSICIAN'S NAME (Type) CHARLES E. SMITH, M.D.		TERRA ALTA WEST VIRGINIA	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal & Burial 5/29/58		22b. DATE THEREOF 5/29/58	
22c. NAME OF CEMETERY OR CREMATORY Terra Alta Cemetery		22d. LOCATION (City, town, or county) (State) Terra Alta, West Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Ed. E. Smith M.D. License No. 6834 ADDRESS Terra Alta, W.Va.		24a. REC'D BY REGISTRAR DATE JUN 4 '58	
24b. REGISTRAR'S SIGNATURE W. E. Smith			

VS A15 (4)
15M 10/57

VS A1S (4)
15M 10/57

DEATH CERTIFICATE

STATE OF NEW YORK

DEATH CERTIFICATE	
STATE OF NEW YORK	
COUNTY OF ...	
TOWN OF ...	
NAME OF DECEASED ...	
AGE ...	
SEX ...	
DATE OF DEATH ...	
PLACE OF DEATH ...	
CAUSE OF DEATH ...	
MANNER OF DEATH ...	
SIGNATURE OF ...	
DATE ...	

DEATH CERTIFICATE

5743 CERTIFICATE OF DEATH

Reg. Dist. No. 05733

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland,		c. LENGTH OF STAY IN 1b 40 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Water Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Elizabeth Ann Kerins		4. DATE OF DEATH Month Day Year May 4, 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 16, 1873
9. AGE (In years last birthday) 84 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work, for self and others		10b. KIND OF BUSINESS OR INDUSTRY West Virginia	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Kerins		14. MOTHER'S MAIDEN NAME Margaret Melvin	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. ----	
17. INFORMANT George Kerins		Address Oakland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 Myocardial Infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardiovascular Disease DUE TO (c) 15-20 yrs.		INTERVAL BETWEEN ONSET AND DEATH 1-2 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from August 1937 to May 1958 , that I last saw the deceased alive on October 1957 , and that death occurred at 5:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Herbert H. Leighton		ADDRESS (Street, city or town, state) 27 Oak St. Oakland, Md.	
DATE SIGNED May 5, 1958		PHYSICIAN'S NAME (Type) Herbert H. Leighton, M. D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/6/1958	
22c. NAME OF CEMETERY OR CREMATORY Catholic Cemetery		22d. LOCATION (City, town, or county) (State) Oakland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE H. Leighton		ADDRESS Oakland, Md.	
24a. REC'D BY REGISTRAR DATE MAY 6 '58		24b. REGISTRAR'S SIGNATURE W. E. Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

5744

CERTIFICATE OF DEATH

Reg. Dist. No.

05734

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND		c. LENGTH OF STAY IN 1b 3 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WEEKS NURSING HOME		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM WRIGHT LEASE		4. DATE OF DEATH Month Day Year MAY 9 19 58	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 14, 1874
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY Self employed	
11. BIRTHPLACE (State or foreign country) Springfield, W. Va.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME FREDERICK LEASE		14. MOTHER'S MAIDEN NAME HARRIETT FLEEK	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT BERNARD LEASE, FROSTBURG, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) AURICULAR FIBRILLATION 420.0 DUE TO ARTERIOSCLEROTIC HEART DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO SENILITY (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-1-57 , 19____, to 5-8-58 , 19____, that I last saw the deceased alive on 5-8-58 , 19____, and that death occurred at 1:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 5-9-58 James H. Feaster, Jr., M.D. JAMES H. FEASTER, JR., M. D. 58 2ND. ST., OAKLAND, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			
22b. DATE THEREOF 5/12/58		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park	
22d. LOCATION (City, town, or county) (State) Cumberland, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Md.		24a. REC'D BY REGISTRAR DATE MAY 14 '58	
24b. REGISTRAR'S SIGNATURE <i>Quinn</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

100

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5745 CERTIFICATE OF DEATH

Reg. Dist. No. **05735**

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland,		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Lake Park,	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Garrett County Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Baby Boy Middle Martin Last 'A'		4. DATE OF DEATH Month May Day 6 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/6/58
9. AGE (In years last birthday) 5		10. IF UNDER 1 YEAR Months 5 Days 45	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) new born baby		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Oakland, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Francis Leroy Martin		14. MOTHER'S MAIDEN NAME Harvey, Rita Joan	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Rita Joan Martin		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity (6 mos gestation) DUE TO 774X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 774X DUE TO (c) 774X	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 5 3/4 hrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5-6 , 19 58 , to 5-6 , 19 58 , that I last saw the deceased alive on 5-6 , 19 58 , and that death occurred at 3:00 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Dr. James H. Feaster Jr.		ADDRESS (Street, city or town, state) Oakland, Maryland	
PHYSICIAN'S NAME (Type) Dr. James H. Feaster Jr.		DATE SIGNED 5-8-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/7/1958	
22c. NAME OF CEMETERY OR CREMATORY Thos. Bernard Cemetery near Mt. Lake Park, Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE H.C. Leighton		ADDRESS Oakland, Md.	
24a. REC'D BY REGISTRAR MAY 9 1958		24b. REGISTRAR'S SIGNATURE Dee Leach	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

05736

5746

1. PLACE OF DEATH o. COUNTY <u>Garrett</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Garrett</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oakland,</u>	c. LENGTH OF STAY IN 1b <u>5 1/2</u> hrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Lake Park, Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Garrett County Memorial Hospital</u>		d. STREET ADDRESS <u>Mothers Residence above</u>	
3. NAME OF DECEASED (Type or print) First <u>Baby Boy</u> Middle <u>Martin</u> Last <u>'B'</u>		4. DATE OF DEATH Month <u>May</u> Day <u>6</u> Year <u>19 58</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/6/58</u>
9. AGE (In years last birthday) <u>5</u> yrs.		IF UNDER 1 YEAR Months <u>5</u> Days <u>4</u> Hours <u>48</u> Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>new born baby</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Oakland, Maryland</u>
13. FATHER'S NAME <u>Francis Leroy Martin</u>		14. MOTHER'S MAIDEN NAME <u>Harvey, Rita Joan</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>---</u>	
17. INFORMANT <u>Rita Joan Martin</u>		Address <u>Mt. Lake Park, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia (6 wks gestation)</u> 774x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>5 3/4 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>5-6</u> , 19 <u>58</u> , to <u>5-6</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>5-6-58</u> , and that death occurred at <u>3:00 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>552-1st OAKLAND - 1</u> <u>5-7-58</u>			
ACTUAL SIGNATURE <u>Dr. James H. Feaster Jr.</u>		PHYSICIAN'S NAME (Type) <u>Oakland, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5/7/1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Thos. Bernard Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>near Mt. Lake Park, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>H.C. Leighton</u>		ADDRESS <u>Oakland, Md.</u>	24a. REC'D BY REGISTRAR DATE <u>MAY 9 1958</u>
24b. REGISTRAR'S SIGNATURE <u>Alfred...</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2270222XVO

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text, possibly "JOHN DOE"]		SEX [Faint text, possibly "Male"]		AGE [Faint text, possibly "45"]	
RACE [Faint text, possibly "White"]		BIRTH DATE [Faint text, possibly "10/15/1910"]		BIRTH PLACE [Faint text, possibly "Baltimore, Md."]	
DECEASED AT [Faint text, possibly "Home"]		DATE OF DEATH [Faint text, possibly "11/1/1955"]		TIME OF DEATH [Faint text, possibly "10:00 AM"]	
CAUSE OF DEATH [Faint text, possibly "Heart Disease"]		MANNER OF DEATH [Faint text, possibly "Natural"]		PLACE OF DEATH [Faint text, possibly "Home"]	
SIGNATURE OF PHYSICIAN [Faint signature]		SIGNATURE OF REGISTRAR [Faint signature]		SIGNATURE OF WITNESS [Faint signature]	
DATE OF SIGNATURE [Faint text, possibly "11/1/1955"]		DATE OF SIGNATURE [Faint text, possibly "11/1/1955"]		DATE OF SIGNATURE [Faint text, possibly "11/1/1955"]	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chicago Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

05737

1. PLACE OF DEATH a. COUNTY Garrett b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland c. LENGTH OF STAY IN 1b --- d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Dragon arrived at G.C.M.H.		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Illinois b. COUNTY Cook c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chicago d. STREET ADDRESS 2047 Grace St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Arthur Middle C. Last Neissner		4. DATE OF DEATH Month MAY Day 31 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 26, 1890
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months --- Days ---	IF UNDER 24 HRS. Hours --- Min. ---
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Leather Company	
11. BIRTHPLACE (State or foreign country) Chicago, Illinois		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Christ Meissner		14. MOTHER'S MAIDEN NAME Ida Arndt	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 337-03-2732	
17. INFORMANT Zimmerman Funeral Home, Forest Park, Illinois.		Address Illinois.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) --- (a), stating the underlying cause last. DUE TO (c) ---			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ---			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH ---	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ---	
20c. TIME OF INJURY Month, Day, Year Hour --- a. m. --- p. m. ---		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ---		20f. (City or town) (County) (State) ---	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE E. I. Baumgartner		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) E. I. BAUMGARTNER		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 5/31/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/3/1958	
22c. NAME OF CEMETERY OR CREMATORY Ridgewood Cemetery, Maine Township, Cook Co., Ill.		22d. LOCATION (City, town, or county) (State) ---	
23. FUNERAL DIRECTOR'S SIGNATURE H.C. Keighton		ADDRESS Oakland, Md.	
24a. REC'D BY REGISTRAR ---		24b. REGISTRAR'S SIGNATURE ---	
DATE JUN 2 '58		DATE ---	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text, possibly "John Doe"]		SEX [Faint text, possibly "Male"]		AGE [Faint text, possibly "45"]	
DATE OF DEATH [Faint text, possibly "Jan 15, 1920"]		TIME OF DEATH [Faint text, possibly "10:30 AM"]		PLACE OF DEATH [Faint text, possibly "Home"]	
OCCUPATION [Faint text, possibly "Teacher"]		CAUSE OF DEATH [Faint text, possibly "Heart Disease"]		MANNER OF DEATH [Faint text, possibly "Natural"]	
SIGNATURE OF EXAMINER [Faint signature]		SIGNATURE OF DECEASED [Faint signature]		SIGNATURE OF WITNESS [Faint signature]	
CERTIFICATE NO. [Faint number]		COUNTY [Faint text, possibly "Baltimore"]		CITY [Faint text, possibly "Baltimore"]	
STATE [Faint text, possibly "Maryland"]		ZIP CODE [Faint text, possibly "21201"]		DISTRICT [Faint text, possibly "1st"]	
DATE OF EXAMINATION [Faint text, possibly "Jan 15, 1920"]		TIME OF EXAMINATION [Faint text, possibly "10:30 AM"]		PLACE OF EXAMINATION [Faint text, possibly "Home"]	
SIGNATURE OF EXAMINER [Faint signature]		SIGNATURE OF DECEASED [Faint signature]		SIGNATURE OF WITNESS [Faint signature]	
CERTIFICATE NO. [Faint number]		COUNTY [Faint text, possibly "Baltimore"]		CITY [Faint text, possibly "Baltimore"]	
STATE [Faint text, possibly "Maryland"]		ZIP CODE [Faint text, possibly "21201"]		DISTRICT [Faint text, possibly "1st"]	
DATE OF EXAMINATION [Faint text, possibly "Jan 15, 1920"]		TIME OF EXAMINATION [Faint text, possibly "10:30 AM"]		PLACE OF EXAMINATION [Faint text, possibly "Home"]	
SIGNATURE OF EXAMINER [Faint signature]		SIGNATURE OF DECEASED [Faint signature]		SIGNATURE OF WITNESS [Faint signature]	
CERTIFICATE NO. [Faint number]		COUNTY [Faint text, possibly "Baltimore"]		CITY [Faint text, possibly "Baltimore"]	
STATE [Faint text, possibly "Maryland"]		ZIP CODE [Faint text, possibly "21201"]		DISTRICT [Faint text, possibly "1st"]	
DATE OF EXAMINATION [Faint text, possibly "Jan 15, 1920"]		TIME OF EXAMINATION [Faint text, possibly "10:30 AM"]		PLACE OF EXAMINATION [Faint text, possibly "Home"]	
SIGNATURE OF EXAMINER [Faint signature]		SIGNATURE OF DECEASED [Faint signature]		SIGNATURE OF WITNESS [Faint signature]	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5748 CERTIFICATE OF DEATH

Reg. Dist. No. **05738**

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Oakland			c. LENGTH OF STAY IN 1b 45 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural Oakland		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3 Mi. West Oakland				d. STREET ADDRESS 3 Mi. West Oakland, Md.		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Marshall Moats				4. DATE OF DEATH Month Day Year May 19, 1958			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 21, 1891		9. AGE (In years last birthday) 67 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Coal Miner and Farmer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Abraham Moats				14. MOTHER'S MAIDEN NAME Virginia Shipp			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 213-10-3724		17. INFORMANT Address Marshall Moats, Jr. Oakland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Stomach 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH 1 1/2 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. _____ p. m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from March , 19 57 , to May , 19 58 , that I last saw the deceased alive on May 15 , 19 58 , and that death occurred at 11:45 P. M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Herbert H. Leighton M.D.				ADDRESS (Street, city or town, state) 77 Oak Street, Oakland, Md. DATE SIGNED May 20, 1958			
PHYSICIAN'S NAME (Type) Herbert H. Leighton, M. D.				Oakland, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/22/1958		22c. NAME OF CEMETERY OR CREMATORY Oakland Cemetery		22d. LOCATION (City, town, or county) (State) Oakland, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE H. C. Leighton				ADDRESS Oakland, Md.		24a. REC'D BY REGISTRAR DATE MAY 23 '58	
				24b. REGISTRAR'S SIGNATURE Overman			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5749

CERTIFICATE OF DEATH

Reg. Dist. No. 05739

1. PLACE OF DEATH a. CITY <u>Garrett</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Garrett</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Friendsville</u>		c. LENGTH OF STAY IN 1b <u>36 yrs.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Friendsville</u>		d. STREET ADDRESS <u>1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>-----</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Quincy</u> Middle <u>Andrew</u> Last <u>Murphy</u>		4. DATE OF DEATH Month <u>May</u> Day <u>25</u> Year <u>19 58</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>Oct. 30, 1880</u>
9. AGE (In years less birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Merchant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General Store</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William A. Murphy</u>		14. MOTHER'S MAIDEN NAME <u>Henrietta Crowe</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>-----</u>		16. SOCIAL SECURITY NO. <u>-----</u>	
17. INFORMANT <u>Robert Murphy</u>		Address <u>Friendsville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Decompensation, Aortic</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardio-Renal</u> DUE TO <u>disease</u> (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 1958</u> to <u>5-22-1958</u> , that I last saw the deceased alive on <u>5-22-1958</u> , and that death occurred at <u>10:00A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>58 21 ST OAKLAND, MD 54-8</u> DATE SIGNED <u> </u>			
ACTUAL SIGNATURE <u>James H. Feaster, Jr.</u>		M.D. <u>58 21 ST OAKLAND, MD 54-8</u>	
PHYSICIAN'S NAME (Type) <u>James H. Feaster, Jr., M. D.</u>		<u>Oakland, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/28/1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Frostburg Memorial Cemetery, Frostburg, Md.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. C. Leighton</u>		ADDRESS <u>Oakland, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>JUN 2 '58</u>		24b. REGISTRAR'S SIGNATURE <u> </u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

5750

Reg. Dist. No. 05740

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland,		c. LENGTH OF STAY IN 1b 40 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Fourth Street		d. STREET ADDRESS Fourth Street	
3. NAME OF DECEASED (Type or print) William Cecil Smith		4. DATE OF DEATH May 23, 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 2, 1898
9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR: Months 59 Days 59 Hours 59 Min. 59	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Banker, Exec. Vice		10b. KIND OF BUSINESS OR INDUSTRY President	
11. BIRTHPLACE (State or foreign country) Maryland.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William A. Smith		14. MOTHER'S MAIDEN NAME Emma Savage	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 213-03-1955	
17. INFORMANT Mrs. Cecil Smith		Address Oakland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 420.1 DUE TO (c) 420.1 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Lithemia of Men 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1954 to May 1958 , that I last saw the deceased alive on May 23, 1958 , and that death occurred at 8:45 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE E. I. Baumgartner M.D.		ADDRESS (Street, city or town, state) 2540 St. Delmondo DATE SIGNED 5/26/58	
PHYSICIAN'S NAME (Type) E. I. Baumgartner, M. D.		Oakland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/26/1958	
22c. NAME OF CEMETERY OR CREMATORY Oakland Cemetery		22d. LOCATION (City, town, or county) (State) Oakland, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE H. C. Leighton		ADDRESS Oakland, Md.	
24a. REC'D BY REGISTRAR JUN 2 '58		24b. REGISTRAR'S SIGNATURE W. H. Leighton	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be given to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

ST. LOUIS, MO. (AP) — A 19-year-old woman was charged with the murder of a 17-year-old man in a St. Louis suburb Tuesday.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5751 CERTIFICATE OF DEATH

05741

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Garrett</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Garrett</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Deer Park,</u>		c. LENGTH OF STAY IN 1b <u>18 yrs.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Deer Park</u>		d. STREET ADDRESS <u>5 Mi. So. Deer Park, Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5 Mi. So. Deer Park</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Emma</u> Middle <u>Parks</u> Last <u>Strawser</u>		4. DATE OF DEATH Month <u>May</u> Day <u>22</u> , Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 8, 1873</u>
9. AGE (In years lost birthday) <u>84</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Lucian Parks</u>		14. MOTHER'S MAIDEN NAME <u>Catherine DeBerry</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>----</u>	
17. INFORMANT <u>Charles Strawser</u>		Address <u>Deer Park, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Heart Disease</u> DUE TO (c) <u>Hypertension and Arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Dead on Arrival</u> <u>43 yrs.</u> <u>8 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>JAN</u> , 19 <u>50</u> to <u>MAY 22</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>MAY 2</u> , 19 <u>58</u> , and that death occurred at <u>3:40 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Ralph Calandrella</u>		ADDRESS (Street, city or town, state) <u>Kitzmiller, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Dr. Ralph Calandrella, M. D.</u>		DATE SIGNED <u>5/25/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/25/1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Eglon Cemetery</u>
22d. LOCATION (City, town, or county) (State) <u>Eglon, Preston Co., W. Va.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>H.C. Leighton</u>		ADDRESS <u>Oakland, Md.</u>	
24a. REC'D BY REGISTRAR <u>DATE JUN 2 58</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Leach</u>	

[The page contains extremely faint, illegible text.]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5752

CERTIFICATE OF DEATH

Reg. Dist. No. 05742

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WEST VIRGINIA b. COUNTY PRESTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TERRA ALTA Rural 85x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL HOSPITAL		d. STREET ADDRESS R. D. #3	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ALLEN Middle Elijah Last UPHOLD		4. DATE OF DEATH Month MAY Day 6 Year 19 58	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 1, 1897
9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm	
11. BIRTHPLACE (State or foreign country) Maryland.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME UPHOLD, JOHN		14. MOTHER'S MAIDEN NAME TEETS, EFFIE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. WW No. 1 213-12-9264	
17. INFORMANT Address LAVINIA UPHOLD (WIFE) TERRA ALTA, W. VA.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 451x Mediastinitis + Pneumonitis DUE TO (b) Dissecting Aortic Aneurysm DUE TO (c) Atherosclerotic Cardiovascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 11 days 11 days 15 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE/CONDITION GIVEN IN PART I (a) 492x Hemiparesis from old Cerebral Vascular Accident		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 19 58 to May 6 19 58 , that I last saw the deceased alive on May 6 19 58 , and that death occurred at 3:15A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Herbert H. Leighton, M.D.		ADDRESS (Street, city or town, state) 27 Oak St, Oakland, Md. DATE SIGNED May 7, 1958	
PHYSICIAN'S NAME (Type) Herbert H. Leighton, M. D.		Oakland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/9/1958	
22c. NAME OF CEMETERY OR CREMATORY Blooming Rose Cemetery		22d. LOCATION (City, town, or county) (State) near Friendsville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE H. C. Leighton		ADDRESS Oakland, Md.	
24a. REC'D BY REGISTRAR MAY 12 58		24b. REGISTRAR'S SIGNATURE W. H. Couch	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5753 CERTIFICATE OF DEATH

05743

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Garrett b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Bloomington c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3 Mi. W. of Bloomington		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Garrett c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Bloomington d. STREET ADDRESS 3 Mi. W. of Bloomington e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Rosa Ellen Warnick		4. DATE OF DEATH Month Day Year May 9 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 13, 1883
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Own home	11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME Messiah Paugh		14. MOTHER'S MAIDEN NAME Emily Harvey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Gail Warnick-Swanton, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis and Myocardial Degeneration Not Specified as Rheumatic DUE TO 422.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 2 Years 2 Years		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) None		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Apr. 10, 1958 , to May 9, 1958 , that I last saw the deceased alive on May 9, 1958 , and that death occurred at 11:35 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Piedmont, N. Va. DATE SIGNED May 10, 1958			
ACTUAL SIGNATURE Paul R. Wilson M.D.		PHYSICIAN'S NAME (Type) Paul R. Wilson M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5/12/58	22c. NAME OF CEMETERY OR CREMATORY Turner Cemetery	22d. LOCATION (City, town, or county) (State) Garrett County Md.
23. FUNERAL DIRECTOR'S SIGNATURE E. L. Boal		ADDRESS Westernport, Md.	24a. REC'D BY REGISTRAR DATE MAY 12 '58
		24b. REGISTRAR'S SIGNATURE Quesada	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form No. 100

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH	
JAMES EARL RAY		Male		35		April 14, 1928		Jackson, Mississippi	
6. OCCUPATION		7. CAUSE OF DEATH		8. MANNER OF DEATH		9. PLACE OF DEATH		10. DATE OF DEATH	
Attorney		Myocardial infarction		Natural		Baltimore, Maryland		April 4, 1968	
11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR		13. SIGNATURE OF DECEASED		14. SIGNATURE OF WITNESS		15. SIGNATURE OF DECEASED	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
16. SIGNATURE OF DECEASED		17. SIGNATURE OF WITNESS		18. SIGNATURE OF DECEASED		19. SIGNATURE OF WITNESS		20. SIGNATURE OF DECEASED	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
21. SIGNATURE OF DECEASED		22. SIGNATURE OF WITNESS		23. SIGNATURE OF DECEASED		24. SIGNATURE OF WITNESS		25. SIGNATURE OF DECEASED	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
26. SIGNATURE OF DECEASED		27. SIGNATURE OF WITNESS		28. SIGNATURE OF DECEASED		29. SIGNATURE OF WITNESS		30. SIGNATURE OF DECEASED	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
31. SIGNATURE OF DECEASED		32. SIGNATURE OF WITNESS		33. SIGNATURE OF DECEASED		34. SIGNATURE OF WITNESS		35. SIGNATURE OF DECEASED	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
36. SIGNATURE OF DECEASED		37. SIGNATURE OF WITNESS		38. SIGNATURE OF DECEASED		39. SIGNATURE OF WITNESS		40. SIGNATURE OF DECEASED	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
41. SIGNATURE OF DECEASED		42. SIGNATURE OF WITNESS		43. SIGNATURE OF DECEASED		44. SIGNATURE OF WITNESS		45. SIGNATURE OF DECEASED	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
46. SIGNATURE OF DECEASED		47. SIGNATURE OF WITNESS		48. SIGNATURE OF DECEASED		49. SIGNATURE OF WITNESS		50. SIGNATURE OF DECEASED	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
51. SIGNATURE OF DECEASED		52. SIGNATURE OF WITNESS		53. SIGNATURE OF DECEASED		54. SIGNATURE OF WITNESS		55. SIGNATURE OF DECEASED	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
56. SIGNATURE OF DECEASED		57. SIGNATURE OF WITNESS		58. SIGNATURE OF DECEASED		59. SIGNATURE OF WITNESS		60. SIGNATURE OF DECEASED	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
61. SIGNATURE OF DECEASED		62. SIGNATURE OF WITNESS		63. SIGNATURE OF DECEASED		64. SIGNATURE OF WITNESS		65. SIGNATURE OF DECEASED	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
66. SIGNATURE OF DECEASED		67. SIGNATURE OF WITNESS		68. SIGNATURE OF DECEASED		69. SIGNATURE OF WITNESS		70. SIGNATURE OF DECEASED	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
71. SIGNATURE OF DECEASED		72. SIGNATURE OF WITNESS		73. SIGNATURE OF DECEASED		74. SIGNATURE OF WITNESS		75. SIGNATURE OF DECEASED	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
76. SIGNATURE OF DECEASED		77. SIGNATURE OF WITNESS		78. SIGNATURE OF DECEASED		79. SIGNATURE OF WITNESS		80. SIGNATURE OF DECEASED	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
81. SIGNATURE OF DECEASED		82. SIGNATURE OF WITNESS		83. SIGNATURE OF DECEASED		84. SIGNATURE OF WITNESS		85. SIGNATURE OF DECEASED	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
86. SIGNATURE OF DECEASED		87. SIGNATURE OF WITNESS		88. SIGNATURE OF DECEASED		89. SIGNATURE OF WITNESS		90. SIGNATURE OF DECEASED	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
91. SIGNATURE OF DECEASED		92. SIGNATURE OF WITNESS		93. SIGNATURE OF DECEASED		94. SIGNATURE OF WITNESS		95. SIGNATURE OF DECEASED	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
96. SIGNATURE OF DECEASED		97. SIGNATURE OF WITNESS		98. SIGNATURE OF DECEASED		99. SIGNATURE OF WITNESS		100. SIGNATURE OF DECEASED	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

1. I hereby certify that the above is a true and correct statement of the facts as they came to my knowledge and belief, and that the deceased died of the cause stated above.

2. I hereby certify that the above is a true and correct statement of the facts as they came to my knowledge and belief, and that the deceased died of the cause stated above.

3. I hereby certify that the above is a true and correct statement of the facts as they came to my knowledge and belief, and that the deceased died of the cause stated above.

4. I hereby certify that the above is a true and correct statement of the facts as they came to my knowledge and belief, and that the deceased died of the cause stated above.

5. I hereby certify that the above is a true and correct statement of the facts as they came to my knowledge and belief, and that the deceased died of the cause stated above.

6. I hereby certify that the above is a true and correct statement of the facts as they came to my knowledge and belief, and that the deceased died of the cause stated above.

7. I hereby certify that the above is a true and correct statement of the facts as they came to my knowledge and belief, and that the deceased died of the cause stated above.

8. I hereby certify that the above is a true and correct statement of the facts as they came to my knowledge and belief, and that the deceased died of the cause stated above.

9. I hereby certify that the above is a true and correct statement of the facts as they came to my knowledge and belief, and that the deceased died of the cause stated above.

10. I hereby certify that the above is a true and correct statement of the facts as they came to my knowledge and belief, and that the deceased died of the cause stated above.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5754 CERTIFICATE OF DEATH

05744

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		c. LENGTH OF STAY IN 1b 5 Months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cuppert Nursing Home		d. STREET ADDRESS 313 Avirett Ave.	
3. NAME OF DECEASED (Type or print) First Jennie Middle Yaksetich Last Yaksetich		4. DATE OF DEATH Month May Day 27 , Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 1, 1883
9. AGE (In years lost birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Yugoslavia		12. CITIZEN OF WHAT COUNTRY? Naturalized U.S.	
13. FATHER'S NAME ? --- Tetrosic		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Allegany Co. Welfare Board		Address Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 434.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Acute Bronchitis			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from John , 19 58 , to May , 19 58 , that I last saw the deceased alive on May 27 , 19 58 , and that death occurred at 12:20 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 25 Alder St Oakland Md DATE SIGNED 5/27/58 ACTUAL SIGNATURE E. I. Baumgartner M.D. E. I. Baumgartner PHYSICIAN'S NAME (Type) E. I. Baumgartner, M. D. Oakland, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/29/1958	
22c. NAME OF CEMETERY OR CREMATORY S.S. Peters & Pauls Cem.,		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR DATE MAY 29 '58		24b. REGISTRAR'S SIGNATURE Dee Smith	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5755

CERTIFICATE OF DEATH

Reg. Dist. No. 05745

1. PLACE OF DEATH a. COUNTY <u>Garrett</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Garrett</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Grantsville, Md.</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Grantsville, Md.</u>		d. STREET ADDRESS <u>1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>IDA</u> Middle <u>ELLEN</u> Last <u>YOMMER</u>		4. DATE OF DEATH Month <u>May</u> Day <u>6</u> Year <u>1958</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June, 2, 1958</u>
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	11. BIRTHPLACE (State or foreign country) <u>Bittering, Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Josiah Bittering</u>	
14. MOTHER'S MAIDEN NAME <u>Katherine Ann Orndorf</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>212-38-6053</u>		17. INFORMANT <u>Mrs. Harry Yommer, Grantsville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension, bronchial asthma</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan. 13</u> , 19 <u>47</u> , to <u>May</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>May 4</u> , 19 <u>58</u> , and that death occurred at <u>11 a</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Grant Atwell</u> M.D.		Meyersdale, Pennsylvania	
PHYSICIAN'S NAME (Type) <u>Grant Atwell</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5/9/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Grantsville</u>	22d. LOCATION (City, town, or county) (State) <u>Grantsville, Garrett Co., Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Grant Atwell</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 12 '58</u>	24b. REGISTRAR'S SIGNATURE <u>W. H. Leach</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH	
6. OCCUPATION		7. MARITAL STATUS		8. COLOR		9. RELIGION		10. EDUCATION	
11. DATE OF DEATH		12. TIME OF DEATH		13. PLACE OF DEATH		14. CAUSE OF DEATH		15. MANNER OF DEATH	
16. SIGNATURE OF PHYSICIAN		17. SIGNATURE OF REGISTRAR		18. SIGNATURE OF WITNESS		19. SIGNATURE OF DECEASED		20. SIGNATURE OF NEXT OF KIN	

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND, AND A COPY IS TO BE FURNISHED TO THE NEAREST RELATIVE OF THE DECEASED.